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Proceedings

1961 Annual Conference

of the **SURGEON GENERAL, PUBLIC HEALTH SERVICE**

and **CHIEF, CHILDREN'S BUREAU**

with **STATE AND TERRITORIAL HEALTH OFFICERS**

November 8-10, 1961

U. S. DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

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Virginia State Department of Health, Richmond

Vice President:
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California State Department of Public Health, Berkeley

Secretary-Treasurer:
Andrew C. Offutt, M.D., State Health Commissioner
and Secretary, Indiana State Board of Health, Indianapolis

Executive Committee:
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Pennsylvania Department of Health, Harrisburg

Ralph E. Dwork, M.D., Director of Health
Ohio Department of Health, Columbus

Wilson T. Sowder, M.D., State Health Officer
Florida State Board of Health, Jacksonville

Floyd I. Hudson, M.D., Executive Secretary
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Public Health Service Publication No. 927

United States Government Printing Office Washington: 1962

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Combined Conferences
of the Surgeon General, Public Health Service, and the Chief,
Children's Bureau, with the State and Territorial Health Officers

General Session — Wednesday, November 8, 1961

Presiding: Dr. Luther L. Terry, Surgeon General

SUMMARY OF OPENING REMARKS

Dr. Terry called the conference to order. In behalf of the Public Health Service, he welcomed the participants and expressed his pleasure in the opportunity to work and talk with them as a group. He stated that although this is his first appearance before these annual conferences in the role of Surgeon General, he nevertheless has long been aware of their importance in developing public health programs affecting the general population. He then introduced the Secretary of Health, Education, and Welfare, the Honorable Abraham Ribicoff--also making a "first appearance" here since taking office in January 1961.

Mr. Ribicoff extended a cordial welcome and his best wishes for a successful meeting. He extended congratulations on the enduring record of cooperative enterprise exemplified in these annual conferences, which for nearly sixty years have contributed basically to public health progress in this country. Mr. Ribicoff expressed deep interest in the productive ideas and programs that would evolve--as always--from the dedicated work of the conferees.

Dr. Terry thanked Mr. Ribicoff, and then presented the next speaker, Katherine B. Oettinger, Chief of the Children's Bureau.

CHILDREN'S BUREAU SERVICES IN 1961

Katherine Brownell Oettinger
Chief, Children's Bureau
Social Security Administration

This year has marked a new intensity of purpose to assure the health of the Nation's children. President Kennedy set the tone of this concern in his health message to the Congress, delivered early in his administration. "The Nation's children," he said, "now 40 percent of our population, have urgent needs which must be met." The President recommended an increase in appropriations for the maternal and child health, crippled children's, and child welfare services programs of the Children's Bureau. "By this means," he said, "the fruits of our research can move at a faster pace to those who need them most."

The Bureau welcomed this enunciation of its continuing and ever-increasing responsibilities toward children as a renewal of the dedication we feel so keenly. We were therefore particularly gratified when the Congress, for the first time, voted appropriations for maternal and child health and crippled children's services in fiscal year 1962 that equal the full amount of the current authorization--$25 million for each program. The appropriation for child welfare services has risen to $18,750,000; and $350,000 is allocated for research and demonstration projects in child welfare under the 1960 amendments to Title V of the Social Security Act.

In the reports of the House and Senate appropriations committees a number of specific areas relating directly or indirectly to health were highlighted as needing more attention. The Senate committee, in recommending an increase in funds for maternal and child health, said in its report: "Infant mortality is rising in the United States; improvement is needed especially in infant clinics and well-baby centers, in vaccination of children of low-income groups against polio, and in health services for the children of migrant workers. The additional funds provided can be well used to help overcome these problems."

The House committee pointed out that over the last several years appropriations have not even kept up with the increase in child population and the increase in costs--let alone provide for any improvement in services. The committee indicated its expectation that the Children's Bureau will use a portion of the increased grants to encourage States to get programs started to combat the illegitimacy problem more effectively.

The committee stressed especially "the plight of unwed mothers in the teen-age group and their children," and urged efforts "to rehabilitate these mothers so that they may become a part of decent society rather than going on to further degradation as now so often happens."

There can be no doubt about the pressing need to do more to combat illegitimacy and to assure that unmarried parents receive the services they need and want. According to the Public Health Service, there were 221,000 illegitimate births in the United States in 1959--the highest number on record. This represents an increase of more than 12,000 over the figure for the previous year. And it represents, of course, only births recorded as illegitimate.

Many of these mothers are scarcely more than children themselves. Recently updated figures not yet published show that 64.8 percent of all unwed mothers in this country have their first child at the age of 19 years or younger. Each year more than 4,600 of these mothers are girls less than 15 years old.

There is considerable evidence that we are not reaching unwed mothers, of whatever age or socio-economic level, with the health and welfare services they need. In a recent study financed by the New York State Department of Social Welfare with Federal child-welfare funds, the Community Council of New York reports that in New York City, at least, many unwed mothers do not avail themselves of existing services. Five hundred and twenty unwed mothers were interviewed shortly after confinement. More than one-fifth had had no prenatal care until the seventh or eighth month, and 17 percent had no prenatal care at all. By way of contrast, among married women, only 3 percent have no prenatal care.

The Children's Bureau and the Bureau of Public Assistance have recently prepared guidelines for the development of community services that will help to counteract the conditions that lead to births out of wedlock. In a publication entitled Unmarried Parents (CB Publication No. 390/BPA Report No. 45, 1961), just released, the two Bureaus have examined the responsibility of State agencies and the community. The need for coordinated action among public health and welfare agencies, school, church, and voluntary agencies, the medical profession, and other groups is stressed.

In order to learn, on a national basis, where we stand in relation to services to unmarried parents, the Children's Bureau recently sent to your States a questionnaire regarding the number and kind of health and welfare services available. We asked the States to respond by November 1, 1961, and we feel sure that much constructive action will grow out of the analysis and new insights provided by this information.

We are able to report progress in the implementation of some of the new legislation discussed last year. We are now able to move forward in international health research, since over $1 million was appropriated for grants relating to maternal and child health and crippled children's services in other countries. We have been fortunate to be able to add Dr. Barbara Hewell to the staff of our Division of International Cooperation. Dr. Hewell has had broad experience within the maternal and child health field at Federal, State, and local levels and with the International Cooperation Administration. We anticipate that Dr. Hewell will soon be making her initial contacts in Israel, Egypt, India, and Pakistan.

You will recall that the 1960 amendments to the Social Security Act, which we discussed last year, authorize the Children's Bureau to make special project grants relating to maternal and child health and crippled children's services directly to universities, medical schools, and schools of public health. The procedures for making these grants were reviewed during the past year with the State health officers and deans of schools of public health, and these procedures have now been put into operation.

The new program of research and demonstration project grants in the field of child welfare, also authorized under the 1960 amendments to the Social Security Act, is now being implemented to make effective use of the initial $350,000 appropriated by the Congress this year. Some of the proposals are of particular interest to both health and welfare disciplines; for example, those relating to homemaker services, day care, and services to unmarried parents.

New legislation this year included passage of the Juvenile Delinquency and Youth Offenses Control Act of 1961, Public Law 87-274. This law, based on the Administration bill, was approved by the President on September 22.

The law provides for a three-year program of:

a. Grants for demonstration and evaluation projects,

b. Grants for short-term training of personnel employed or to be employed in the prevention or control of juvenile delinquency or youth offenses, and

c. Technical assistance service from the Department of Health, Education, and Welfare to public and private agencies and institutions.

An annual appropriation of $10 million for implementation of this act was authorized for fiscal years 1962, 1963, and 1964. The act will be administered by the Secretary of Health, Education, and Welfare, working closely with the President's Committee on Juvenile Delinquency and Youth Crime, which was appointed to bring about a more effective coordination of Federal resources in this field. This committee includes the Attorney General as chairman, and the Secretary of Labor, along with the Secretary of Health, Education, and Welfare.

I have summarized these new developments in relation to juvenile delinquency because I know that physicians--in their professional meetings and elsewhere--have given specific evidence of interest in their own vital role in combating this immense national problem.

Legislation now pending before the Congress includes the bill known as H.R. 9299 and S. 2273, which would amend Title V of the Social Security Act to permit the Children's Bureau to make grants for program-related research in maternal and child health in this country. Both this bill and its Public Health Service counterpart (S. 2269), which would provide for establishment of an Institute of Child Health and Development, have Administration support. Sent to the Congress simultaneously, the bills complement rather than duplicate each other. The Public Health Service bill is oriented toward basic research in child development, while the Children's Bureau bill is concerned with evaluation of programs, trying out new public health procedures, and other operational or applied research. We anticipate that this may be actively considered by the next session of Congress.

I know that all of you have been interested in another new development--the recent appointment of the President's panel on mental retardation. The panel includes outstanding physicians, scientists, educators, lawyers, psychologists, social scientists, and other leaders in the field of mental retardation, and is under the chairmanship of Leonard Mayo. The President has asked the panel to explore ways to prevent and cure mental retardation; to study the scope and dimensions of the biological, psychological, educational, vocational, and socio-cultural aspects of the problem; and to appraise the adequacy of existing programs and the possibility for greater utilization of current knowledge. The panel has been asked to submit its report on or before December 31, 1962. The Department of Health, Education, and Welfare's committee on mental retardation has been reactivated in order to be ready to work closely with the President's panel in whatever ways may be required, and I am sure the State agencies will also be evaluating how they can contribute to this new effort in mental retardation.

The Children's Bureau has recently completed a progress report on health services for mentally retarded children covering the years 1957-1961. Never

before have we been able to identify such rapid growth in a particular program area.

As you all know, in 1957 the Congress earmarked $1 million of maternal and child health funds for demonstration projects in clinical services for mentally retarded children. By the end of 1960, forty-six States and Territories were providing some special clinical services to retarded children and their families. Fifty of the Nation's 82 special clinics for retarded children have been developed through this program.

We know that much of the speed with which new concepts of help for mentally retarded children have been put into practice is due to the enthusiasm and hard work of the State health departments. The small spark struck only a few years ago has ignited a rapidly spreading fire of action on behalf of this formerly neglected group of children.

Almost all the public mental retardation projects are using the services they provide to train a variety of professional workers. More than 200 specialists from various disciplines have been recruited and trained to provide services and leadership in programs for the mentally retarded. More than 25,000 public health nurses have received some inservice training or orientation in mental retardation and in assisting families in the home care of mentally retarded children.

Fourteen of the projects are set up in conjunction with medical schools, where the projects are being used as the basis for training medical students, residents, interns, and nurses. Some 4,500 medical students, residents, and interns and more than 1,200 nursing students have received some training.

Since 1957, more than 25,000 retarded children have been given complete evaluation and follow-up care. Currently about 10,000 children per year are being served.

In many of the programs, emphasis on prevention of retardation is heavy. Twenty-six States have set up screening programs for detection and treatment of phenylketonuria, the inborn error of metabolism that results in severe retardation if not diagnosed and treated early. Within the past year, more than 25 infants with PKU have been located, diagnosed, and placed on preventive diets.

The growing interest of physicians and public health workers in the PKU problem is mirrored in their response to Phenylketonuria (CB Publication No. 388, 1961) published in June of this year. Already more than 21,000 copies have been sold. Several State health departments are ordering the publication in quantity for distribution to their public health workers. Under the title, "The Clinical Team Looks at Phenylketonuria," the Children's Bureau has also reproduced a collection of papers dealing with this problem from the standpoint of the pediatrician, the public health nurse, the medical social worker, biochemist, psychologist, and nutritionist.

In order to determine the effectiveness of current PKU treatment and diet therapy, the Children's Bureau, on the advice of its Technical Committee on Clinical Programs for Mentally Retarded Children, has been developing the design for an evaluative study. A preliminary inquiry has already gone out to the States to determine the number and age of children with PKU who have been or are now known to mental retardation clinics throughout the country. The type of dietary supervision and follow-up services provided will be studied, as well as the settings and facilities of clinics that have children with PKU under care, and the laboratory and psychological testing procedures used. The age at which

dietary therapy was instituted will be evaluated in relation to the child's mental and physical development. We anticipate that a pilot study, to test the study design, soon will be undertaken in a few clinics.

A review of all children with congenital heart disease served through the crippled children's program from 1957 through 1960 is also under way. The care of children with this condition has been one of the most rapidly growing services in the crippled children's program in recent years. In 1950, twenty-eight States had programs under which such children received care. In the succeeding decade the number of States with such programs had almost doubled. The number of children with congenital heart disease who were served in crippled children's programs throughout the country had risen from a little over 2,000 in 1950 to nearly 17,000 in 1960.

The study is expected to answer questions about the age at which diagnosis was made, the kind of diagnostic work-up done, the survival rate with and without surgery, the medical and surgical complications observed, and the nature of revaluation and follow-up done in relation to cases diagnosed prior to recent surgical and other therapeutic developments.

The Children's Bureau's cystic fibrosis project has continued to move ahead this year, and during the appropriations hearings both the House and Senate reiterated their interest in its progress. The final report on the second phase, a three-State pilot study of the magnitude of the cystic fibrosis problem, is now in preparation. The third phase of the project was initiated in the spring of 1961. About 5,000 sources in 17 eastern States and the District of Columbia will be queried for demographic and diagnostic information about cases of cystic fibrosis seen by them since January 1952.

I understand you have recently attended the meeting on fall-out called by the Public Health Service. The Children's Bureau is mindful of its own dual responsibility in relation to radiation hazards, both in assuring that X-ray and fluoroscopy in public health programs for children are so used as to minimize unnecessary exposure, and in interpreting technical information about radiation hazards to parents and others responsible for the care of children.

The problems of migrant children and their families have been of particular concern to the Children's Bureau this year. The report requested by the Senate appropriations committee, "Children in Migrant Families," summarized available information about existing conditions and problems and emphasized needs for health services and child welfare services, including day care. In preparing this report the Bureau drew upon material and studies developed by a wide variety of groups, and a questionnaire submitted to national voluntary organizations and State public health and welfare agencies.

The replies underlined our concern about the scarcity of services and facilities and the limited financial and staff resources available to improve the situation. We have, however, been pleased to see the development of new services to migrants in a few States. For example, in one southern State a demonstration project in homemaker services has been started. The aim of the project is to see that migrant children have a chance to develop better living standards. Homemakers prepare the noon meal, so that the health of the children will be protected by their having at least one adequate meal per day. Several States have made specific provision for services to the children of migrants in their budgets for 1962. A considerable portion of the money will be used for day care.

The Children's Bureau has recently approved a five-year special project plan for migrant agricultural workers in California. The plan is the outgrowth

of several years of effort on the part of an interstate committee representing health agencies, medical societies, church programs, county boards of supervisors, and volunteer workers. Its purpose is to promote better health for migrant children and their families, and to demonstrate the potential for effective coordination of public and voluntary health services on an interstate basis. Eleven western States will be included, as will Texas, which is a major "supply State" for families who migrate to the other States to work. There will be special effort to overcome intercultural and other barriers between health workers and families to be served. There will also be efforts to find ways to educate and motivate migrant families to take responsibility for meeting their own health needs.

I know that many of you have felt the need for special health education materials designed for migrant and other families of limited cultural and educational levels. In response to your requests, the Children's Bureau has recently issued a picture leaflet containing in simplified form the information in our brochure of long-standing popularity, Prenatal Care (CB Publication No. 4). The new leaflet, called When Your Baby Is On The Way (CB Publication No. 391), will be translated into Spanish so that it can be used by Puerto Rican mothers in the large urban centers of the east and by Spanish-American mothers in the border States of the south. We hope to produce in the future similar materials on other topics.

Preliminary plans for the celebration of the fiftieth anniversary of the Children's Bureau have been moving ahead both within the Bureau and through groups representing interested citizens and national organizations. A planning session of the Citizens Committee for the Golden Anniversary Celebration of the Children's Bureau was held in New York day before yesterday, and the warm enthusiasm expressed for this opportunity to focus public attention on the needs of children was very gratifying.

The celebration will dramatize national concerns for children, with the purpose of strengthening programs, services, and facilities for child health and welfare in America today. It will review Federal concerns for children and highlight the Children's Bureau's responsibilities in the light of changes in the last fifty years and opportunities in the years ahead.

The Bureau is continually aware of the tremendous part such agencies as those you represent have played in assuring the effectiveness of its programs. As we celebrate this Golden Anniversary, we shall look ahead to an ever more productive joint effort on behalf of children and their families.

SUMMARY OF DISCUSSION BY DR. TERRY

Dr. Terry thanked Mrs. Oettinger for her excellent report. In recognition of the heavy agenda over the next three days, he stated that he would take only enough time to discuss several broad areas in which the Public Health Service and State health officers are working for expansion of efforts. He was particularly pleased to note that tomorrow's afternoon session would be devoted to:

Metropolitan Health Problems

Herein lie both the opportunity and the necessity for intensified Federal-State-local governmental action. Undoubtedly, the next few years will see increased Federal aid, in forms as yet undetermined, to metropolitan areas. With nearly two-thirds of our U. S. population in the 212 standard metropolitan statistical areas, the special needs of urban people will obviously claim more attention. This does not indicate any change in Federal-State relations in existing health and welfare programs. It does indicate, however, that State and Federal agencies must work for more effective relationships with city health organizations.

We must recognize that the quality of State-city relationships varies from place to place. Perhaps now is the time for States to review their roles, not only in the setting of standards and enforcement of regulations, but also in supporting the efforts of city health departments to improve services in their areas.

The Public Health Service intends to strengthen its performance in programs that involve regulatory functions, and hopes States will do the same. The Service also plans to increase its advisory and technical services on metropolitan problems, if possible.

This past year, the Service established for the first time a small Metropolitan Planning and Development Branch in the Division of Environmental Engineering and Food Protection. The unit will provide liaison with experts in the field, whether working in other Federal agencies, State or local governments, planning commissions, universities, or elsewhere.

The Environmental Health Planning Guide (PHS Publication No. 823), published this year, has been enthusiastically received by many health departments and metropolitan planning commissions. It provides a detailed description of an area survey covering air pollution, sewerage, water supply, housing, and refuse disposal. The Guide has been tested in Lake County, Illinois; Albuquerque, New Mexico; Fort Wayne-Allen County, Indiana; and Omaha-Douglas County, Nebraska. With the approval and consultation of the Washington State Health Department, a large-scale survey is now in progress in the Seattle-King County area. Some 25 to 30 local jurisdictions, in addition to the city of Seattle, are actively involved and various planning bodies are included.

Another 1961 publication is the report prepared by a joint committee of the American Hospital Association and the Public Health Service. Entitled Areawide Planning for Hospital and Related Health Facilities (PHS Publication No. 855), this report emphasizes problems of metropolitan areas.

We are aware that some PHS laws have hampered State plans for increasing support to cities, but there are encouraging signs of improvement:

(a) Legislation enacted in the first session of the 87th Congress provides increased authorization of construction grants for municipal waste treatment

facilities and liberalizes the allotment of grants to larger cities. The appropriation for 1962 under this authorization is $80 million.

(b) We are hopeful that amendments to the Hill-Burton Act will be passed in the next session to provide for replacement and new construction in metropolitan areas.

Environmental Health

In environmental health, PHS activities are expanding, but much more is needed to meet the future requirements of this country. Last August a special committee was appointed to develop long-range objectives for PHS environmental programs, including manpower needs, intra- and extramural research, and relationships with other agencies. Dr. Paul Gross, president-elect of the American Association for the Advancement of Science, served as chairman; and Dr. Malcolm Merrill as a member. After three months of intensive work, the committee's report was received last week.1/ The conclusions, in general, were:

(a) This Nation needs a vigorous, integrated effort to identify and cope with its environmental health problems.

(b) Current PHS programs in this field need closer coordination.

(c) A strong focal center is needed to execute an expanded program from a wider legislative base.

Another noteworthy event is the passage of the National Milk Sanitation Act, supported by the Association of State and Territorial Health Officers.

In shellfish sanitation, the certification program remains on a voluntary basis. Several shellfish sanitation problems that arose last year, plus the fact of virus transmission through shellfish, indicate that we need increased research, closer State surveillance, and stronger enforcement at all levels of water pollution control. The PHS shellfish laboratory in Rhode Island has been established, and authorization and funds for others have been received.

Radiation exposure is a matter of growing concern throughout the world; it affects all PHS environmental health programs; and the entire network of Federal, State, and local surveillance systems is heavily involved.

The recent conference on radiation data involved State health authorities, so that details need not be repeated here. The PHS statement received wide publicity. Several interesting recommendations out of that conference were:

(a) That the Public Health Service make greater effort, whenever possible, to give States new data in advance of release to the press--possibly through teletype network or telephonic alert to States specifically concerned.

(b) That States develop their own monitor systems to supplement PHS systems.

(c) That although it was agreed that no counter measures are presently needed, both the Public Health Service and the States should consider what counter measures they would take under different situations.

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1/ Editor's note: Published in March 1962, entitled Report of the Committee on Environmental Health Problems (PHS Publication No. 908).

(d) That more trained manpower is needed; the PHS training program should be stepped up; and States should seek authorization for more personnel at their level.

Community Health Services and Facilities Act of 1961

As the only other legislation affecting health agencies passed by the first session of the 87th Congress, its provisions are undoubtedly familiar enough to this group to require only a brief review, as follows:

(a) The act raises the ceiling on formula grants to States for general health services to $50 million for 5 years;

(b) Authorizes the earmarking of appropriations under this title for particular purposes;

(c) Authorizes the assignment of PHS personnel to States in lieu of a limited proportion of formula grants;

(d) Establishes project grants to public and private nonprofit organizations for experiments and demonstrations in the improvement of community health services, outside of hospitals, at $10 million a year for 5 years;

(e) Raises the ceiling on research grants in hospital administration and design to $10 million;

(f) Raises the ceiling on construction grants for nursing homes to $20 million for 3 years;

(g) Liberalizes requirements for rehabilitation facility construction grants so that more hospitals may establish medical rehabilitative services;

(h) Increases authorization for grants to schools of public health; and

(i) Extends health research facilities construction one year and increases grants authorization to $50 million.

On the administration of the act, the following points are summarized:

(a) A majority of the provisions will be administered by the Bureau of State Services. The health research facilities program will remain in the National Institutes of Health.

(b) All provisions of the act affecting the Hill-Burton program, as amended, will be under the direct administration of the Hospital and Medical Facilities Division. Policy guidance and research grant recommendations will be provided by the Federal Advisory Hospital Council. The Conference of State Hospital Authorities and the Conference of Mental Health Authorities will also advise on the Hill-Burton program.

(c) Earmarked formula grants to the States under this act will be made through the Grants Management Branch, Bureau of State Services, with program direction by the Division of Chronic Diseases.

(d) Project grants will be administered on a Bureau-wide basis. All divisions concerned with community health will be represented on a project review committee with the associate bureau chief for community health (Dr. Aaron

Christensen) as chairman. Management aspects of the grants will be administered by the Grants Management Branch.

The significance of the act for health and medical care can be summed up as follows:

(a) Its provisions for experimentation in community services outside of hospitals and increased experimentation within hospitals mark a great step forward. In the past, not more than $5 million a year from all sources has been spent in this country for research and development in hospital administration and general community services. The act makes possible a four-fold increase in the Nation's investment in this highly productive type of experiment: $10 million was received this year for hospital research and $2.9 million for special projects in community services. Projects under both these provisions of the act will explore technical and operational methods that build the bridge between medical science and application.

(b) What can be accomplished through this act in the years immediately ahead? Wisely used, the earmarked formula grants will enable State health departments to expand local programs in community health services already begun, and also to set up special project grants to community organizations. In addition, many well qualified organizations, including hospitals, will be encouraged to develop coordinated programs providing the continuum of services all long-term patients require--in the home, the clinic, the nursing home, and in the special and the general hospital. Once physicians and patients experience such high quality services they surely will never go back to the old, haphazard way of overlong hospitalization, followed by care inadequate to the continuing needs of the patient. Each such shift in attitude and demand will be another step toward more efficient use of health and medical resources, another step toward better care of the sick.

International Health

There are signs of increasing responsibilities for the Public Health Service in international health. Time permits mention of only a few highlights at this point.

The Humphrey amendment, Section 621(a), of P.L. 87-195 passed by the Congress, together with certain Administration actions, denotes that existing Federal agencies that have been active domestically in the health field shall be consulted and used in promoting foreign programs. Approved in September 1961, P.L. 87-195 is the act that transformed ICA under the Department of State into a new segment, the Agency for International Development (AID).

Also, the Public Health Service recently assumed the medical staffing responsibility for the Peace Corps. Dr. Leo Gehrig has been assigned as chief of the Medical Program Division of the Corps, in addition to ten or twelve other PHS professional persons assigned here and abroad. These activities are likely to be expanded.

An Office of International Research has been created at the National Institutes of Health, to coordinate all international research activities and provide direction for NIH foreign research activities supported through U.S.-owned foreign currencies.

Last year about $3.7 million of foreign currency was available to support medical research developments abroad. This year about $9 million is available for use by NIH, the Bureau of State Services, and the National Library of Medicine.

Five international centers for medical research and training have been established: in Malaya, Colombia, India, Pakistan, and Costa Rica. Another has been authorized for Ghana. PHS grants are made to universities in this country to establish these centers in cooperation with foreign medical institutions. The Congress provided $5 million to initiate the program, which will provide training of medical personnel in the United States and abroad, as well as the primary research objectives.

The Division of International Health in the Office of the Surgeon General, now under the direction of Dr. James Watt, is also expected to play an increasingly important role and to be the focal point for overall PHS international activities.

(End of this Session)

METROPOLITAN HEALTH PROBLEMS

Presiding: D. G. Gill, M.D., Chairman
Ad Hoc Committee on Metropolitan Planning

Background:

The 1960 census for the 50 States and District of Columbia showed a total population of 179,300,000--an increase of nearly 19 percent over the 1950 figure.

Seven out of every 10 inhabitants in the United States are urban residents. The 1960 urban population is 29 percent greater than in 1950. This urban population growth occurred in all 50 States, despite decreases in many of the larger cities.

The 1960 census listed 215 Standard Metropolitan Statistical Areas (SMSA), as defined by the Bureau of the Budget and the Federal Committee on SMSA. This figure includes 1 such area in Hawaii and 3 in Puerto Rico. The definition involves two considerations: (1) a city or cities having 50,000 or more population to constitute the central city and identify the county in which it is located as the central county; and (2) economic and social relationships with contiguous counties metropolitan in character.

The 212 SMSA's within the United States now contain 63 percent of the population. Almost 85 percent of the total population increase between 1950 and 1960 occurred in SMSA's; but the relative increase in the suburban ring was almost five times as great as for the central cities themselves.

Public Health in the Metropolitan Setting

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The trend to concentration of population in metropolitan areas has been evident for more than 50 years, and is continuing. In 1910 the United States had 44 metropolitan areas. The 1950 census listed 168; and the 1960 census listed 211 Standard Metropolitan Statistical Areas in the continental United States.

The city or the suburb is now the birthplace, playground, and place of work for the majority of American people. Even the life-long farmer is likely to retire to an urban community in a southern State.

It is in an urbanized environment, then, that most individuals are exposed to, or protected from, health hazards. When illness occurs, the medical care

facilities of the metropolitan area are used not only by the residents therein but also frequently by those from outlying rural areas.

Solely on the basis of numbers of persons involved, public health in the metropolitan setting warrants greater attention. For the public health worker, there are other reasons to justify this concern. For the public health administrator, these three questions have particular pertinence:

1. What is the metropolitan area? More specifically, what is the metropolitan area from a public health point-of-view?

2. Are there unique medical or other public health problems associated with the metropolitan area?

3. Are there special administrative advantages or problems in developing public health programs for metropolitan areas?

In this three-point outline, specific reference to the political structure of the metropolitan area is omitted. Important as political structure may be, I want to point out other more basic considerations than those of boundary and jurisdictional lines of city versus suburb, city government versus State government. It is unfortunately true that metropolitan area government is no one's business. Within recent years there have been a number of proposals to provide such government by political centralization. Metropolitan problems, however, such as air pollution, water supply, traffic control, and the like, occur under every form of political structure here and abroad. Governmental reorganization is not likely to solve public health problems that stem from industrial activity and other nonpolitical aspects of metropolitanization.

Let us turn now to the first question, "What is the metropolitan area?" For the public health worker, it is not primarily a particular set of political jurisdictions, nor is it satisfactorily defined in terms of population density. The metropolitan area is a complex economic and social unit with many interrelated functions and sections.

In general, we are only beginning to develop information and concepts on what the metropolitan area is and which aspects are especially important to consider in public health practice. As a physician, I find it appropriate to suggest that knowledge of the structure and function of metropolitan areas is just as essential to understanding its public health problems as is a physician's knowledge of gross anatomy and physiology in dealing with his patients' health problems. The analogy, for the physician at any rate, suggests the need to identify the location and function of specialized subunits and also how the parts relate to the whole; to identify the metropolitan area not only as a geographic, political, and population unit, but also as a functioning unit with specialized subunits. It can be expected that definitions used by different metro specialists will vary, and that what may be essential for identification in public health may be irrelevant in political science, or vice versa. As in the comparison of simple and complex multicellular organisms, there will be certain basic similarities between urban and rural communities--and equally likely, some great differences.

The basic factors that determine the location and growth of metropolitan areas apparently are the economic and industrial. Therefore, public health similarities may be expected among cities with similar economic specialization, wherever they may be. Nevertheless, a steel city in the Ruhr is not Pittsburgh or Birmingham, essentially because of dissimilarities in the cultural and political backgrounds. Thus, public health problems and programs will be influenced in a different way.

In addition to identifying industrial and cultural factors, there is a great need to clarify the real limits and functions of the metropolitan area--what is urban or suburban, central city or satellite city?--as well as the definitions of the words so used. In public health, variations in definition may cause confusion in functional or causal relationships. As an illustration, we often see reference made to the "metroplex" centered around New York City and extending north to Boston and south to Washington; and sometimes the suggestion that this "conurbation" is a community with common problems. Of course, some common problems exist within this area of industrial and population concentration. Actually, however, exact knowledge is quite scanty on what problems are common as a result of such agglomeration of metropolitan areas.

This discussion of the problems of definition and of identifying relationships is intended primarily to direct attention to the fact that metropolitan areas are organized, functioning, and complex areas in their own right. In clinical medicine, physicians and medical students sometimes need to be reminded that the patient is a person as well as a case. In metropolitan analyses, public health administrators and other specialists also should remember to pay attention to the over-all character as well as the separate parts and problems of an area. Each specialist should know the limits of his competence and accept the need for coordination with others. For example, if economic and industrial factors are primary determinants of metropolitanization, as suggested earlier, then we must improve both our understanding and relationships in the field of industrial planning. The Committee on Economic Development is one demonstration of the interest of business and industry leaders in metropolitan area planning and activities.

Now for our second question on whether and how metropolitanization affects the health of individuals and groups.

The metropolitan area has important connotations in epidemiology, and for the public health administrator it must be identified in the same way that the industrial environment is identified for the specialist in occupational medicine and industrial hygiene.

It is well known that population density can critically influence disease occurrence and distribution, and thus becomes a major public health concern. In addition to population concentration, the metropolitan area also has power-use and waste-production concentration. For example, we are increasingly concerned about air pollution resulting from concentrated multiple sources (such as automobiles, factories, and incinerators), and the possible health hazards it may present to the large metropolitan population. We do not have sufficient information to set standards for community air quality to match those established for inplant industrial air quality. Nevertheless, it is evident that industrial and population concentration will require program action by the public health engineer and other environmental health specialists.

What about some other health effects of city living--those in which it is more difficult to find accepted evidence of relationship? Several pioneering studies done by social scientists have provided the best evidence that neighborhoods of low economic status have their own patterns of social interaction and the highest rates of mental disorder, tuberculosis, and venereal disease; and that middle and high status neighborhoods have other patterns of social, economic, and health relationships. Public health programs in metropolitan areas should be adapted to these different neighborhood patterns. Bradley Buell has recommended an approach in which a family is given a social diagnosis and upon which staff interaction is planned. This could be a desirable approach, for example, in staff planning for a family in which tuberculosis has been found. Epidemiology studies of selected

population groups would have value not only in developing disease incidence information but also for application to direct service programs.

Sociologists, welfare workers, and city planners will be interested in health effects as well as other aspects of metro living. When public health workers become involved in concerns such as urban renewal, they have the primary responsibility of identifying the health effects of metropolitanization and of interpreting these to other professional specialists as well as responsibility for health program execution.

I want to emphasize this public health responsibility for better health data, especially because there have not been, to my knowledge, any Federal, State, or local programs that regularly analyzed and published standard vital statistics data on metropolitan areas, as such. Comparable and operative vital statistics of this kind, plus more refined epidemiological information, are needed for greater precision in health program planning for metropolitan areas and their subdivisions.

This leads into our third question on how best to organize for public health administration in the metropolitan setting. The basic problems will be those of any large organization--be it industrial or governmental--and will not be necessarily peculiar to metro public health administration.

In this connection, two aspects deserve comment here. First, little information is available that would be helpful in the organizing phase or in the identification of program responsibility. If we had such information it would show, for example, not only a staff pattern for an environmental health program but also where agency responsibility lies, among different departments of local government, for specific activities such as air pollution control, housing hygiene, and the like.

The second aspect concerns the general tendency to focus on area-wide planning and control, and to deplore fragmentation among various political subdivisions. Area-wide planning and action is certainly important for some purposes, but equally important is the development of decentralized plans and programs fitted to particular subdivisions.

Few studies have been published about administrative organization of local health units in large-population areas. No consensus has been established, moreover, on the optimum population size for effective administration or on the degree of program authority to be decentralized from central headquarters to district units. Some time ago, the accepted standard was a population of 50,000 as the minimum that could support efficient and economical service. There has been little discussion, however, about a practical maximum size of population for an integrated public health unit.

My experience in St. Louis County indicated that it is difficult to administer standard public health services from a single central headquarters when the population exceeds 400,000. In Pittsburgh and Allegheny County, several years of experience indicate that a public health unit can be well related to districts having a population of 300,000.

In conclusion, let me say now that all my foregoing points are only part of the broad picture. We must keep clearly in mind that the ultimate recipient of metropolitan public health services is still the individual within a family and in a neighborhood, and that this neighborhood is part of a city, a ward, or it may be an independent suburban municipality. Administratively, the question of "breaking up" a centralized program in a city of more than a half million population deserves

as much attention as that of "centralizing" plans for such a city and its politically independent suburbs.

Recent voter responses indicate that major governmental reorganization in metropolitan areas is unlikely. Furthermore, metropolitan growth is indifferent to municipal and county boundary lines, which suggests limitations in their usefulness as a base for programs. Thus, it may be necessary to look to the development of patterns other than that of political reorganization or centralization. The next few years will probably bring forth tests of several different mechanisms, such as special governing units for sanitary sewer districts as described by Ballens.

In the meantime, a number of administrative actions can be taken--often within existing authority--by Federal, State, and local officials. Some examples are:

1. Organizing records and reporting systems to conform to metropolitan areas. A typical method would be that of consolidating the reports for a central city with those of the surrounding urbanized county or counties.

2. Requiring coordinated planning and programming by local officials who apply for grant-in-aid funds for local programs within a metropolitan area. This device might well foster the habit of cooperative, area-wide planning even beyond the grant-aided programs. State and Federal agencies, in general, tend to deal with individual political jurisdictions rather than with coordinated groups of municipalities; and sometimes the agencies have actually discouraged cooperative efforts by local municipalities.

3. Involving and delegating to local agencies certain metropolitan-wide responsibilities. In many instances, some State responsibilities are now delegated to local health departments as a matter of regular policy. Arrangements could undoubtedly be made to extend and ensure the performance of appropriate delegated services over a metropolitan area. Particular attention should be given to the use of formal contractual agreements between various governmental units within an area, and between municipal jurisdictions and the State and Federal governments. The contract as an administrative device can produce far more coordination and flexibility in public health services than does political change by charter amendment.

There are precedents in public health programs for each of these three actions. Plans sometimes become difficult or impossible to carry out when political changes that only secondarily involve public health are delayed or opposed. The importance of political organization should not be overstressed. Many other approaches to metropolitan area planning for public health are now open within existing administrative and legislative powers.

The need to improve public services for metro area residents is undeniable and is recognized at every level of government, as well as in private and business life. Any attempt to predict future patterns or changes would have little value. Certainly health programs will be affected as changes occur. What may be less obvious is that action to improve health programs frequently has served as a model for improving other kinds of programs. Area-wide sewer districts, city-county health departments, local-State-Federal cooperative programs in disease control are all examples of this. Certainly there is real evidence of increasing interest, so that we can reasonably expect a consolidation of past gains. From this base and with adequate epidemiologic data to support recommendations for

program changes, the public health administrator will be able to work more effectively to meet metropolitan health problems.

Environmental Engineering Problems

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Electrical engineers use the term "positive feedback." It means that if power is applied continuously to a motor, part of the output may be fed back to the motor in such a way as to amplify the input. Under certain conditions the input may be increased to such an extent that the motor will literally explode.

There is an analogy, perhaps imperfect, between positive feedback and the rapid development of our metropolitan areas. Every day larger numbers of people, more materials, and more power are being funneled into our urban areas, which are approaching a limit in terms of their size and physical expansion. Although a considerable part of the industrial and commercial output of cities is widely dispersed, the remainder is consumed by the city itself. But more important, from the standpoint of health, a growing volume of waste is fed back into the city in the form of garbage and refuse, and air, water, and soil pollutants. If these byproducts are not satisfactorily disposed of, their feedback could eventually destroy as effectively as a deadly epidemic.

The rapid growth of cities, together with technological innovation, has brought the inevitable decay, obsolescence and conflict of interest--and this partly explains the growth of suburbia. However, the areas available for suburban development are diminishing, and if people live too far away this destroys the convenience which makes cities necessary in the first place. On the other hand, there is increasing acceptance of the urgent necessity to keep our core cities both viable and efficient if the metropolitan area is to remain effective.

A hopeful development is the growth of metropolitan planning, a conscientious attempt to review and analyze on a metropolitan-wide basis. Until recently, sporadic planning was largely confined to individual communities or to certain types of utilities or services. Out of the defined 212 metropolitan areas in 50 States, more than 70 now have metropolitan planning agencies.

An inherent difficulty which planners face is a lack of fundamental planning principles. It is important to think of the metropolitan area as a cohesive whole and to recognize the interplay of social, political, and economic factors. But the city of the future is daily being "positively planned" by the streets and highways, sewer lines, water lines, reservoirs, and garbage dumps that are being built. Health and health-related departments have a direct responsibility, not only for many of the utilities which form the skeleton of the city, but also for the well-being of the population—and thus a vital interest in such problems as overcrowding, the location of parks and of health facilities, and the quality of food, air, and water supply. Metropolitan planners and health groups should now develop closer working relations, for the degree of this cooperation can literally spell success or failure for the future character and viability of metropolitan America.

A wide range of problems must be faced, and new techniques in systems analysis and operations research provide the possibility of better understanding of individual problems and their interrelationships as well.

As an illustration, let us examine briefly the problem of sewerage and drainage. Most engineers now agree that the method of choice for urban areas is sewers that separate storm water from sanitary sewage. This permits more effective treatment of sewage and less pollution of streams. It is further agreed that, having no inherent virtue in themselves, sewer lines should be designed for minimum length and minimum cost consistent with safety and efficiency. This is quite different from the haphazard method of first laying out lots and streets and simply providing the services wherever needed.

Many engineers also agree that storm drainage is essentially a problem of storage, and that roofs, borrow pits, parks, and reservoirs should all be used, where economically justified, in storing or ponding storm water so as to diminish peak flows in sewers. This is the antithesis of the idea that good drainage consists in getting storm water off as quickly and as completely as possible by the use of paved ditches, direct connection of downspouts to sewers, and the like.

Storm water deserves serious consideration for its inherent value as a resource. Water is urgently needed in most metropolitan areas to provide dilution for sewage treatment plant effluent, for the recharge of depleted ground water tables, or for recreational purposes. This approach leads into the use of open space for storage, recharge, or recreation; and therefore the reservation of suitable tracts of land. At this point, other uses for open space or land demand consideration; for example, parks, garbage dumps, the alleviation of overcrowding, the dilution and absorption of air pollution.

There is no more effective way of justifying planning standards than to relate them directly to health standards, since in the final analysis this is a health problem that will shortly involve some 75 percent of our population in the metropolitan regions. The need for a direct and intimate association between metropolitan planners and health officials is urgent.

Intergovernmental Relations and Public Finance

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In an era when we hear so much about the cultural and scientific lag, we could well devote more thought to what might be called the governmental or political lag--caused by the inevitable procedural requirements, better known as red tape, of government and its slow response to fundamental social and economic changes.

This failure of government to react promptly and decisively to major changes in our society is apparent in many fields--especially the problems stemming from the urbanization and suburbanization of American society. The 1960 census has confirmed what the 1950 census predicted: the continuing concentration of population in Standard Metropolitan Statistical Areas. Not only is the country now urban, it is becoming more so. What does this mean for government organization and public finance?

It is generally believed that urban areas require more government services than rural areas, and thus are more costly. In total cost it is true, but on a per capita basis it is less evident. Total local expenditures in New York City in 1959 averaged $216 per capita. A number of rural counties in the State had slightly higher expenditures per capita.

The pattern of expenditures, however, differs substantially. For example, education expenditures per capita in New York State run from one-third to two-thirds higher in rural and suburban areas than in the cities. Highway expenditures on a per capita basis are considerably higher in rural areas than in the cities, sometimes as much as ten times. City costs are higher for the traditional urban services--police, fire protection, and sanitation.

The relationship of urbanization to government costs is shown by examining the composition of these expenditures. Government functions costing more in the cities are the traditional ones that have always made urban costs high. On the other hand, the greater costs for education and highways in rural areas are a result of the urbanization impact. Speed highways are needed in, rather than by, rural areas, as a consequence of our urbanized economic system. Similarly, it is more expensive for rural people to keep pace with the educational standards required by our highly technical interdependent economic system--also related to urbanization.

The high government cost of urbanization is demonstrated, at least in part, by the extraordinary rise at the local level. Since 1946 local expenditures have been rising more rapidly than national income. Using New York State as an example, for the decade 1949 to 1959 total local expenditures increased by 111 percent; and per capita expenditures by 87 percent. During this same period, per capita personal income in the State increased by 57 percent--or 30 percent points less than local government per capita expenditures. State and Federal expenditures also increased, but the Federal increase is largely accounted for by larger defense expenditures. A great deal of the State increase is used to aid local government--in New York State, more than half is so used.

The impact of metropolitan growth has been even greater on income sources than on expenditure needs. Difficulties surround not only the kind of taxes to be employed but also the jurisdiction from which they must be drawn. It is the combination of these factors that has started processions of hat-in-hand local officials to State capitals and to Washington.

Let's look first at the chief source of locally raised revenue. It is the property tax--much maligned over the years--but it still provides the basic wherewithal for most local governments. In New York State, property tax provided the same percentage of local revenue in 1959 as it did in 1949. For the most part, only large cities and urbanized counties have turned to substantial use of local non-property taxes.

The property tax, d spite continued use, is particularly prone to taxpayer resentment because of its lack of direct relationship to ability to pay. Property is no longer the source of most people's income and has, therefore, only an indirect relationship to the taxpayer's income. Further, it has a high visibility since it normally requires an annual or semi-annual lump sum payment or is paid through the monthly mortgage payments. The almost yearly notice from the bank that these payments must be increased to cover higher taxes often upsets carefully designed household budgets organized around what was assumed to be a stable monthly mortgage installment.

The property tax is also growing obsolete, since the size of many of the jurisdictions that levy it bears little relationship to the facts of the private economic system. As the Advisory Committee on Local Government has said, "The growth of private business into larger units has also made it necessary for the larger private businesses to be taxed by the national and state governments instead of local governments since the properties and income of such private companies cannot be adequately reached by any single local government."

This difficulty is most evident in tax on personal property. Again the Advisory Committee explains the situation well when it points out that "this tax is becoming obsolete because of the mobility of personal property, the use of small local inventories by companies doing a large volume of business, and the complaints of small, independent merchants who see their larger competitor paying taxes on relatively small stocks of goods. Intangible property is free to seek the most favorable tax sites, to move temporarily during the assessable period, or to follow the movement of the principal office of a business. Thus the city of Highland Park, Michigan, lost 25 percent or more of its assessed valuation two decades ago when the Ford Motor Company moved its offices from Highland Park to Dearborn, Michigan. Thus, too, the bank deposits of Illinois businesses and individuals, taxable as personal property, take an annual journey to New York just as individuals go to favorable climates to escape hay fever." The personal property tax has been constitutionally prohibited in New York.

If the property tax possesses these shortcomings, why does local government not turn to other kinds of taxes? To some degree they have, particularly large cities; and, to a lesser extent, urbanized counties. A few cities levy a payroll tax. In Pennsylvania it is widely used; also in St. Louis, in ten cities in Ohio, and four in Kentucky. The sales tax is used by almost every jurisdiction in California and by a few large cities outside this State--New York City, New Orleans, and Denver among them. Excise taxes on cigarettes, liquor, and admissions are also employed in some local jurisdictions.

Generally, however, non-property taxes are not attractive to localities and for good reason. The best tax sources--income, sales, and excises--have been largely preempted by the Federal government and the States. Even if this were not the case, most of these taxes could not be used locally. The local jurisdictions are too small and the taxes are difficult and expensive to administer.

The multiplicity of local government jurisdictions is the major obstacle--particularly in metropolitan areas. The title of a recent book about the New York metropolitan area, 1400 Governments, clearly illustrates this. Every other major metropolitan area faces the same obstacle. The 212 metropolitan areas in the country comprise not 212 but 16,976 governments.

Not only are there many governments but, equally important, they overlap. Let's look at a concrete example. Citizens of Park Forest, a suburb near Chicago, are directly concerned with the following local governments: Cook County, Will County, Cook County Forest Preserve District, Park Forest Village, Rich Township, Bloom Township, Munce Township, Suburban Tuberculosis Sanitarium District, Bloom Township Sanitary District, Mon-High School District 216, Mon-High School District 213, Rich Township High School District 227, Elementary School District 163, and South Cook County Mosquito Abatement District.

The difficulties such a governmental patchwork causes in the administration of activities having area-wide or even partial area application are obvious. Such problems as economical mass transit, air pollution, water supply and pollution, adequate recreation facilities and parks, to name but a few, are difficult enough to solve when considered in the abstract. Trying to solve them within the present

hodge-podge of local government causes many citizens to look outward to State capitals and Washington for help.

As troublesome as administrative performance is financing. Carl Chatters has observed that "The metropolitan areas problem is primarily a public finance problem." It may now be clear why non-property taxes are not a realistic alternative in those areas. Escape is too easy. Sales taxes or local income taxes would only drive business and residents across the nearest border--and normally this would not involve a long move. Oftentimes, just across the street would be far enough. Such taxes would of course be possible if all or nearly all the units would agree to levy them. Such cooperation, however, is not likely.

Two other public finance problems are created by this crazy-quilt system of government. One is the great disparity in the quality of the revenue bases. Communities side by side may have such a different mix of property types that in one district a low rate will produce a high revenue yield, while in a nearby area a rate many times higher will provide financing for only a minimum level of government service. A concrete example is taken from California and the Los Angeles metropolitan area. The City of Los Angeles has 10,000 times the population of its suburban neighbor, Vernon, but it has only 20 times Vernon's assessed value. The property tax base in Vernon amounts to about $1 million per person; in Los Angeles, only $1,000 per person.

Further, the present jurisdictional system makes it almost impossible to relate benefits and taxes. The daily mobility of population means that a person will use the services of many jurisdictions, particularly of the central city, while paying taxes to another.

The result is that the jurisdictions look to the State and Federal governments--seldom to area-wide cooperation. The varying needs of the jurisdictions make local cooperation difficult. A community with a good property base is not eager to combine with one having a poor base. For social and economic reasons, suburban communities want nothing to do with the central city.

The local reasons for not cooperating are reinforced by the belief that State and Federal governments have superior resources which they owe to the local communities. After all, local residents pay the State and national taxes. Thus, the demands for State aid have become insistent. Success has varied from State to State and from jurisdiction to jurisdiction, but there is some uniformity in the pattern that has developed.

To understand this pattern it is necessary to know something about State legislatures. Let me quote from an official government document, the Report of the Advisory Commission on Intergovernmental Relations:

> Much has been written about the rural domination of State legislatures; the basic facts are well established and there is no need to document here the various examples . . . of the relative underrepresentation, from a population standpoint, of urban areas in one or both houses of State legislatures. 'Rural domination' of State legislatures has frequently been a cause for just complaint by metropolitan areas. . . . Also, frequently, 'rural domination' has afforded a made-to-order argument for municipal and other local governments in the metropolitan areas to seek redress from the Congress in the form of financial assistance from the national government.

The statistical evidence that rural and suburban areas fare better than cities in terms of financial aid is quite clear, although there is some variation. New York City, for example, received $49.24 per capita in State aid in 1959 compared

with $62.18 per capita for suburban Nassau County. In fact, New York City ranked 56th out of 58 counties in amount of aid received; i.e., it was third from the bottom. Only Albany and Westchester counties ranked lower.

These differences are not explainable in terms of local fiscal ability. In fact, measures of local fiscal ability are notoriously inadequate since they are usually related, to the extent they exist, to the local property base. This base, unrelated as it is to local income, has at best an indirect relation to real local fiscal ability. Further, since aid programs are usually provided for specific functions, those jurisdictions with important unaided functions are bound to suffer. Cities lose on this score, too, since they do have major expenses in such areas as police, fire, and sanitation, which are not aided at all or at best very little. Were it not for welfare assistance, which is primarily aided by the Federal government, cities--at least in New York State--would really be without major functional aid.

On the other hand, rural and suburban districts have relatively smaller expenditures in unaided areas and substantial aid in functions that represent major expenditures for them; i.e., highways in the rural areas and schools in both rural and suburban. In most suburbs, 50 percent or more of total local expenditures today are for education; and in more and more rural areas this ratio is being approached. In such counties in New York State, highway per capita expenditures are second only to education.

It should be mentioned that suburban areas gradually are being faced with rising non-school municipal costs. They have just passed through a period of sky-rocketing school costs and now a similar burst in municipal costs apparently is just around the corner.

Cities, faced with an unfriendly political climate in their Statehouses and a State-aid pattern not particularly related to their needs, are looking elsewhere. One response has been a wider use of non-property taxes than has been adopted by other local jurisdictions. This response, however, has grown increasingly unpopular as cities find themselves in competition with neighboring suburban areas for residents and business concerns. More and more, Washington is being approached for help.

The pattern of suburban political behavior is less clear. Thus far, in most States, the response from the State capital has been fairly good. The Harvard political scientist, V. O. Key, has suggested: "At times the ingredients are proportioned to produce government of the metropolis, by the country for the suburbs."

What about the future?

1. Public costs at the local level will continue to increase.

2. Extensive government reorganization at the local level is unlikely.

3. State and/or Federal aid will increase more rapidly than other kinds of local revenue.

The Report of the Advisory Commission on Intergovernmental Relations sums it up well when it says:

> If the States do not give cities their rightful allocation of seats in the legislature, the tendency will be toward direct Federal-municipal dealings. These began in earnest in the early days of the depression. There is only one way to avoid this in the future. It is for the State to take an interest in urban problems, in metropolitan government, in city needs. If they do not do this,

the cities will find a path to Washington as they did before, and this time it may be permanent, with the ultimate result that there may be a new government arrangement that will break down the constitutional pattern which has worked so well up to now.

Community Motivation

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Community motivation significantly influences metropolitan area development. A small-town type of community may be more easily motivated than a large city, but in either case the interest and involvement of metropolitan-area jurisdictions will be influenced by such factors as their government structure, activities of locally owned businesses, and—above all--the degree of leadership available. When this leadership for metropolitan area development is based in city and county governments, it perhaps becomes the strongest force for community motivation.

Organizations are often formed to bring metropolitan representatives together to discuss mutual problems and how they might be handled. These organizations can contribute in many ways, but for obvious reasons can become unwieldy when firm decisions and actions need to be taken.

The growth of metropolitan areas has had a great impact on political parties and their activities. An example would be when the central city begins to lose its power and identity within an expanding area. A political party can act to bridge the gap between the central city and the spreading suburbia.

We must not underestimate the great importance of qualified professional personnel in metropolitan government. Difficulties in decentralization are often caused by a lack of professional depth in governmental fields and jurisdictions. One community may support a strong modern public health program, to the extent that its neighboring community may have neither the incentive nor the ability to do likewise. Progress in public health and other aspects of metropolitan development needs strengthened understanding and relations between communities. Community motivation to this end deserves more study and emphasis, and behavioral scientists and those in related fields should take the lead. Success in all phases of metropolitan development can really demonstrate the viability of democracy.

Metropolitan Area Developments in California

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In California, 90 percent of the people live in nine metropolitan areas. Area-wide organizations are needed to resolve area-wide problems.

California cities, in general, have turned over the provision of health services to the county level of government. This has been done either through contracts between the city and the county or, as is possible under California law, through resolution of the city council. With the extension of metropolitan areas, even county boundaries are becoming artificial, and other organizational patterns are being considered.

The California legislature has authorized the establishment of two planning regions for hospitals and health services. They center around Los Angeles in the south and San Francisco in the north, and each region has a committee of ten members. These two committees are expected to coordinate planning for facilities and health services for the areas they represent. The committees have no enforcement powers.

Sixteen years ago the State legislature enacted a public health assistance act, designed to encourage the development of local public health services. Although this assistance has been available to either city or county units, the trend has definitely been toward the provision of county-wide health departments. Only five cities still operate their own health departments.

There is significant legal basis in California for developing metropolitan area activities. California has metropolitan water districts, metropolitan utility districts, air pollution control districts, and transit districts. All these districts operate within a definite legal framework for operational and control activities.

(End of this Session)

RECOMMENDATIONS
OF THE
STATE AND TERRITORIAL
HEALTH OFFICERS

November 10, 1961

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ENVIRONMENTAL HEALTH COMMITTEE

Chairman:	Russell E. Teague, M.D.	Kentucky
Vice Chairman:	James R. Amos, M.D.	North Dakota
Members:	J. T. Herron, M.D.	Arkansas
	Joseph E. Cannon, M.D.	Rhode Island
	Richard H. Wilcox, M.D.	Oregon
	Kirk T. Mosley, M.D.	Oklahoma
	R. L. Cleere, M.D.	Colorado

The State and Territorial health officers recommend:

1. Sanitation Program for Harbors, Ports, Inland and Recreational Waters

That the Public Health Service develop a program for harbors, ports, inland and recreational waters (including control of discharge of wastes from vessels), which can be implemented by State and local health sanitation agencies.

2. Quality Control for Reclaimed Waste Waters

That the Public Health Service develop (a) recommended laboratory procedures, and (b) biological, microbiological, viral, physical, chemical, and radiological quality criteria, for waters reclaimed from sewage effluents and other waste liquids.

3. National Standards for Basic Data on Water and Sewerage Systems

That the Public Health Service confer with State sanitary engineers on the desirability of establishing national standards for recording and reporting basic data on water and sewerage systems.

4. Increased Emphasis on Food Protection

That States, counties, and municipalities expeditiously adopt the new Public Health Service food service ordinance and code; and that the Public Health Service plan now for increased technical and consultative services in food sanitation, particularly to provide assistance in the training of health department sanitation personnel in the interpretation of the technical and administrative provisions of the ordinance and code, and where indicated to promote demonstration projects to implement its field application.

5. Revisions of Public Health Service Recommended Ordinances

That the Public Health Service, in cooperation with representatives of the States and of industries involved, establish an effective and continuing procedure for keeping the various recommended sanitation ordinances and codes correct with changes in technology and practices.

6. Bus Sanitation

That the Public Health Service design a program in cooperation with the Association of State and Territorial Health Officers to regulate the sanitation of buses, bus depots, and bus servicing facilities.

7. Swimming Pool Sanitation

That the Public Health Service strengthen and expand its activities in the field of public swimming pool sanitation to provide State health departments with current and up-to-date information. Primary consideration should be given to research, standards development, and technical assistance in cooperation with health agencies and others.

8. Grants for Radiological Health

That, in view of the urgent need for increased radiological health activities including surveillance and monitoring of air, milk, food, and water for radioactivity, support of Public Health Service financial grants to the States for these activities be reaffirmed.

9. Safety Standards for Coin-operated Dry Cleaning Machines

That, in view of the potential health hazards of coin-operated dry cleaning machines, the Public Health Service in cooperation with the industry study and develop safety standards for the installation and operation of such machines.

Association actions:

10. Air Pollution Control

That the Federal air pollution program be strengthened by: (a) providing for an expansion of research related to the causes, effects, and control of air pollution; (b) providing Federal technical and financial assistance to States and localities in the development and support of programs to apply more effectively existing and future knowledge of the actual control of air pollution; and (c) providing through the Public Health Service of the U. S. Department of Health, Education, and Welfare vigorous leadership to obtain increased attention and devotion of greater resources to the problem of air pollution by all levels of government, industry, and the public.

11. National Milk Sanitation Act

That the Association reaffirm its support of the National Milk Sanitation Act to the appropriate legislative committees of the United States Congress and solicit support of health and consumer groups.

12. Milk Marketing Bill Health Provisions

That the Association of State and Territorial Health Officers hereby goes on record as being opposed to the provisions of H.R. 2061, Sec. 3, and that the secretary be directed to forward to the Committee on Agriculture, House of Representatives, the United States Congress, a copy of this recommendation.

13. Shellfish Sanitation

That each State and Territorial health officer review and strengthen shellfish sanitation programs used in their States so as to exclude shellfish as a source of disease.

14. Zoning and Planning

That the Association of State and Territorial Health Officers commend State and local health departments currently involved in residential environment programs, and urge all departments to take a greater interest in zoning and planning.

FEDERAL RELATIONS COMMITTEE

Chairman:	D. G. Gill, M.D.	Alabama
Vice Chairman:	G. J. Van Heuvelen, M.D.	South Dakota
Members:	G. S. T. Peeples, M.D.	South Carolina
	R. N. Barr, M.D.	Minnesota
	E. A. Rogers, M.D.	Nebraska
	Carl N. Neupert, M.D.	Wisconsin
	John H. Venable, M.D.	Georgia

The State and Territorial health officers recommend:

1. Data Related to Metropolitan Planning

That each State health department provide for the collection and transmittal to the Public Health Service of information on legislative, administrative, fiscal, and other developments relating to metropolitan planning, and

That the Public Health Service, through its metropolitan planning and development activities, collate and distribute pertinent information so collected to the several State health departments and other interested groups.

2. Communicable Disease Reporting

That hospitals of the Public Health Service, Armed Forces, and Veterans Administration, and other Federal hospitals and clinics be encouraged to give maximum cooperation to their jurisdictional health departments by promptly reporting all communicable diseases and positive laboratory findings on communicable disease.

3. Validation of Categorical Grant Expenditures

That the Public Health Service and Children's Bureau further study and explore the possibility of simplification of the means of validation of the expenditure of categorical grant funds.

4. Uniform Project Grant Application Forms

That the Children's Bureau and the Public Health Service be encouraged to develop a uniform application form to be used by the States in seeking special grants to cover all types of projects administered by the Children's Bureau and the Bureau of State Services of the Public Health Service.

5. Federal Contract Forms

That the Public Health Service be requested to initiate a study of possible revisions of present forms of contracts used for contractual relationships between the Federal and State governments.

6. Need for Conferences, Institutes, Seminars, Etc.

That the Public Health Service, through its various branches, materially increase its attention to the basic value and necessity for the conferences, institutes, seminars, etc., which it promotes or sponsors and to which it invites State health department personnel.

Association actions:

7. Metropolitan Area Health Activities

That the State and Territorial health officers encourage and assist in the creation and establishment of such organizations and agencies in metropolitan areas as might properly undertake coordinated, cooperative studies, surveys, planning, and programs related to such area-wide problems as environmental health and other community health problems.

8. Food and Drug Inspections

That the Association of State and Territorial Health Officers support legislative proposals that would give the Food and Drug Administration full powers of inspection over all premises and processes where drugs, foods, and cosmetics for interstate commerce are manufactured, processed, or packaged for distribution; and that the secretary of the Association inform the Secretary of the U. S. Department of Health, Education, and Welfare of this recommendation.

9. Ingredient Labels on Processed Foods

That the Executive Committee continue to maintain liaison with the Food and Drug Administration on such matters as improving the quality of information about ingredients which appears on the labels on processed foods.

HOSPITAL AND MENTAL HEALTH COMMITTEE

Chairman:	Malcolm H. Merrill, M.D.	California
Members:	Robert B. Aiken, M.D.	Vermont
	Charles L. Wilbar, Jr., M.D.	Pennsylvania
	Ralph E. Dwork, M.D.	Ohio

The State and Territorial health officers recommend:

1. Federal Assistance for Hospital Planning in Urban Areas

That the Surgeon General recommend Federal legislation to be administered through the State hospital survey and construction authorities for the purpose of securing the development of a coordinated program of facilities and services that will ensure quality care at the lowest possible cost; and that such legislation should:

a. Provide financial assistance to the several States on a continuing basis to survey the need for modernization, expansion, replacement, and new construction of care facilities in urban areas; and for the provision of consultation and assistance to local planning agencies in the development and implementation of local plans for hospital and medical facilities; such funds also to be available to the States for the purpose of stimulating and analyzing local planning and determining the validity and reasonableness of incorporating local and regional plans, in whole or in part, as integral parts of the overall State plans.

b. Provide financial assistance in the form of special project grants for local planning bodies on a continuing basis to develop and implement comprehensive and coordinated plans for medical care facilities and services in those communities or regional areas, such grants to be made to local planning bodies only after submission of applications to and the approval of such grants by the appropriate State hospital survey and construction authority.

2. Financial Assistance for Urban Facilities

That the Surgeon General recommend Federal legislation to be administered through the State hospital survey and construction authorities to provide financial assistance in the modernization, expansion, replacement, and new construction of care facilities in urban areas of the States. It is emphasized that funds provided for this purpose should be over and above those funds necessary to carry out the present provisions of the Hill-Burton Act.

3. Funds for Hospital Program Administration

That the Public Health Service again seek to amend the Hospital and Medical Facilities Survey, Planning, and Construction Act to provide financial assistance on a matching basis to all States for the improvement of the administration of the program.

4. Wage Rate Determinations

That the Public Health Service seek to amend the provisions of Title VI of the Public Health Service Act so as to exempt Hill-Burton construction from the provisions of the Davis-Bacon Act.

5. Housing for the Aged

That the Public Health Service request the Housing and Home Finance Agency to consult with the State Hill-Burton agencies prior to approving applications for the construction of housing for the aged under the housing for the elderly program.

6. Psychiatric and Long-Term Care Needs

That the Public Health Service initiate studies to develop more precise methods for estimating bed needs, especially for psychiatric and long-term care.

Association actions:

7. Joint Commission and Ad Hoc Committee Reports

That the final report of the Joint Commission on Mental Illness and Health entitled Action for Mental Health (New York, 1961, 338 pp.) and the report of the Surgeon General's Ad Hoc Committee on Planning for Mental Health Facilities entitled Planning of Facilities for Mental Health Services (PHS Publication No. 808, 1961) be commended to the attention and careful consideration of the State and Territorial health officers for individual use as desired, and that such actions and recommendations as may be appropriate be presented to the Association at its next regular meeting.

8. Demonstration Training Programs

That State health authorities avail themselves of the opportunity provided under the authority of the research and demonstration program of the Division of Hospital and Medical Facilities to develop on a demonstration basis (a) refresher training courses for presently employed paramedical personnel; (b) inservice training of aides for the various categories of professional personnel.

INFECTIOUS DISEASES COMMITTEE

Chairman:	R. H. Hutcheson, M.D.	Tennessee
Vice Chairman:	A. L. Gray, M.D.	Mississippi
Members:	James W. Sampson, M.D.	Wyoming
	Edmund G. Zimmerer, M.D.	Iowa
	J. E. Peavy, M.D.	Texas
	Edwin O. Wicks, M.D.	Alaska
	Lloyd M. Farner, M.D.	Arizona
	Stanley J. Leland, M.D.	New Mexico

The State and Territorial health officers recommend:

1. Report on Division of Foreign Quarantine

That endorsement in principle be given to the "Summary of Recommendations Contained in the Review of Activities, Division of Foreign Quarantine, U.S. Public Health Service," prepared by Hollis S. Ingraham, M.D., dated March 23, 1961, with the following reservations:

a. That Recommendation No. 5 not be construed to preclude changes in the law and the regulations which implement the law so that the result will be a more effective exclusion of cases of active or potentially active tuberculosis, better control of individuals with conditions which cannot be so defined and yet deserve control, and less interference or delay in the case of aliens who actually have no excludable condition.

b. That Recommendation No. 10 be construed as applying in the case of any area where establishment of such status would increase the hazard of introduction into the United States of communicable disease.

c. That this endorsement of the recommendations in principle does not constitute an endorsement of the statement of findings upon which the recommendations are based, inasmuch as the findings of this report do not constitute the sole basis for the Conference's endorsement of the recommendations.

2. Live Oral Polio-Vaccine Programs

That the Communicable Disease Center of the Public Health Service test and evaluate, wherever possible, acceptance of community saturation programs with live oral polio-vaccines, so that future programs may know the advantages and disadvantages of the previous experiences in their planning of community-wide programs.

3. Public Health Service Ad Hoc Committee Report

That the revised recommendations of the Public Health Service Ad Hoc Committee dated August 1961 be approved with the exception that the Recommended Form for Reporting Tuberculosis Cases be deleted from the report.

4. Commercial Microbiologic Diagnostic Reagent Standards

That the Public Health Service establish standards and test the commercial diagnostic reagents in microbiology.

5. Public Health Service Regional Laboratory Facilities

That the Public Health Service contract with States or make grants to States for the provision of laboratory services and training facilities, instead of establishing its own regional laboratory facilities.

6. State Virus-Diagnostic Laboratories

That the Public Health Service plan now to increase the availability of reference services for the typing of viral isolates including the identification of vaccine poliovirus; resume the supplying of diagnostic antigens to State laboratories; and investigate the possibility of resumption of financial assistance to State virus-diagnostic laboratories.

7. State Venereal Disease Training Programs

That the Public Health Service take such action as may be necessary in order to provide State venereal disease control programs with additional trainees, experienced trainee supervisors, and funds for supplies and travel.

8. Swine Brucellosis Eradication

That the Public Health Service and the several State and Territorial health departments intensify the national brucellosis eradication program with the objective of eliminating swine brucellosis as rapidly as possible, in view of the epidemics of human brucellosis in many areas, and in view of the increased incidence of swine brucellosis during the past five years to the point where it is now the major cause of human brucellosis among farmers and food processors.

Association actions:

9. Live Polio Vaccine Procedures

That appropriate representatives of the Association of State and Territorial Health Officers, the Public Health Service, the American Academy of Pediatrics, and the American Medical Association develop a uniform position on the procedures for giving live poliomyelitis vaccine.

10. Reporting of Reactive Serologic Specimens

That State health departments implement existing authority which requires that all laboratories (public, private, hospital, and blood bank) processing serologic tests for syphilis report all reactive serologic specimens, by name of patient, to health departments, or that in the absence of existing laws or regulations State health departments take whatever steps are necessary to bring about the enactment of laws or regulations which require such reporting.

11. Diagnostic Laboratory Surveillance

That the several State and Territorial health departments provide the necessary additional space, personnel, and laboratory animals for increased diagnostic laboratory surveillance; develop special virologic and serologic programs in addition to routine diagnostic services; and develop systems for the rapid notification to epidemiologists of the receipt of specimens and the reporting of final identification of viral agents.

LONG-TERM ILLNESS AND HEALTH OF THE AGING COMMITTEE

Chairman:	Bernard Bucove, M.D.	Washington
Vice Chairman:	Perry F. Prather, M.D.	Maryland
Members:	Mary E. Soules, M.D.	Utah
	Roscoe P. Kandle, M.D.	New Jersey
	H. M. Hardwicke, M.D.	Missouri
	Daniel Leo Finucane, M.D.	District of Columbia
	Franklin D. Yoder, M.D.	Illinois
	Joseph E. Cannon, M.D.	Rhode Island

The State and Territorial health officers recommend:

1. Rehabilitation for Independent Living

That the principle of "independent living" embodied in HR 3523 be endorsed, but that Section 203 of Title II of the bill as presently written be amended to allow the individual States to designate the State health agency to administer such plan; and further, that the Secretary of the U. S. Department of Health, Education, and Welfare review carefully the extent to which the aims of HR 3523 can be achieved through the Community Health Services and Facilities Act (PL 87-395).

2. Review of Educational Programs

That the Surgeon General appoint a committee of representatives from State and local health departments, medical schools, preventive medicine departments, public health schools, training schools of allied health professions and services, and related professional organizations, such committee to review the adequacy of the present educational programs in terms of health department center activities, particularly regarding out-of-hospital services for the chronically ill and the aged, and make such recommendations as are deemed appropriate.

Association actions:

3. Water Supply Sodium Content Information for Practicing Physicians

That its members institute a program, whereby in keeping with the usual practice of the individual State health department the sodium content of community water supplies can be made known to the practicing physicians.

4. Home Nursing Care Programs

That the State and Territorial health departments provide leadership in making home nursing care programs an integral part of generalized public health.

5. Placement of Handicapped Persons

That the State and Territorial health departments cooperate with appropriate agencies in programs of basic research and practice application for placement of handicapped persons, for example:

a. Finding suitable employment for employable, disabled persons,

b. Placement of nonemployables in optimum living situations,

c. Assist in providing spare-time activity including education, reading, hobbies, recreation, and social contacts.

6. Lung Cancer

That each State and Territorial health officer work with representatives of the medical societies and other interested groups in his State or Territory to call greater attention to the scientific findings relating cigarette smoking to lung cancer.

7. Vision Conservation

That State and Territorial health officers recognize the importance and practicability of early detection of visual impairments as a means of preventing or reducing the amount of visual loss and blindness that occurs in the United States, and that they exert every effort to include vision conservation activities as an integral part of their respective health department programs.

MATERNAL AND CHILD HEALTH COMMITTEE

Chairman:	J. W. R. Norton, M.D.	North Carolina
Vice Chairman:	Robert H. Riedel, M.D.	Kansas
Members:	Joseph Kovacs, M.D.	Guam
	Daniel J. Hurley, M.D.	Nevada
	Guillermo Arbona, M.D.	Puerto Rico
	William J. Rein, M.D.	Louisiana
	G. D. C. Thompson, M.D.	Utah

Association actions:

1. Care of Children in Hospitals

That the State health departments, in cooperation with State hospital construction authorities, and other interested professional groups, provide consultation to hospitals in order to improve the care of children in hospitals.

2. Prenatal Care

That the several State and Territorial health departments, with the cooperation of the Children's Bureau, study the causes contributing to the decline of interest in prenatal care with the purpose of stimulating further appropriate interest and support.

3. Infertility

That the several State and Territorial health officers encourage the study of the problem of infertility with special reference to establishing services that will help more women to conceive and carry their babies to term.

4. Screening for Phenylketonuria

That the several State and Territorial health departments endorse and promote the routine screening for phenylketonuria by private physicians and health departments.

5. Child Care and Hygiene Training

That the State departments of health in cooperation with the departments of education, evolve a plan of training for high school students in the basic elements of child care and hygiene.

6. Prevention and Control of Juvenile Delinquency

That State and Territorial health officers make use of existing child health services in the prevention and control of juvenile delinquency.

RESEARCH COMMITTEE

Chairman:	Albert E. Heustis, M.D.	Michigan
Vice Chairman:	Herman E. Hilleboe, M.D.	New York
Members:	Alfred L. Frechette, M.D.	Massachusetts
	Albert V. Hardy, M.D.	Florida

The State and Territorial health officers recommend:

1. Development of Public Health Research

That the Public Health Service and the Children's Bureau, through both their central and regional offices, expand their consultation to State health departments in the development of all aspects of public health research.

2. Improved Methodology for Research in Public Health Administration

That the Children's Bureau and the Public Health Service, through both the Bureau of State Services and the National Institutes of Health, give high priority to the development and support of studies designed to improve methodology for research in public health administration, in order to enable the more common undertaking of productive research within ongoing service programs of State and local health departments.

3. Research and Training Institutional Grants

That the Public Health Service reconsider its policy of excluding State health departments from participation in the "institutional grants" to promote research and training authorized by the Congress in P.L. 86-798.

4. Health Education Methods Research

That the Public Health Service take appropriate action to increase research in the broad area of health education methods, including:

a. The stimulation and support of cooperative studies and research programs in State health departments.

b. The provision of training grants to initiate and improve training programs to prepare research workers.

c. The provision of funds for research training fellowships.

d. The stimulation and support of research programs in State health departments and other educational institutions in which fellowship students can work and learn.

e. The institution of a strong research program in this broad area within the Public Health Service itself.

5. Sanitary Piping Systems within Buildings

That the Public Health Service initiate a research and development program in problem areas of hydraulics, pneumatics, and design engineering of sanitary piping systems within buildings and disseminate the information so gained to public health agencies, design engineers, and the plumbing industry.

Association actions:

6. Research Project Development

That each State and Territorial health department develop one or more specific research projects and forthrightly seek support for the same from its State or Territorial legislature.

7. Essential Segments of Public Health Programs

That each State and Territorial health department include in its broad informational activities directed to its employees and the public the concept of service, research, and training as the three essential segments of a well rounded public health program.

8. Arden House Conference on Nutrition Research

That the individual State and Territorial health officers review and support the recommendations of the Arden House Conference on Nutrition Research, which was sponsored by the Research Policy Committee of the APHA and by the Committee on Nutrition of the Association of State and Territorial Public Health Nutrition Directors.

9. Disposal of Solid Municipal Wastes

That the Association support in principle legislation which has been proposed (S-2009) to authorize a program of research and technical assistance relating to the disposal of solid municipal wastes.

SPECIAL HEALTH AND MEDICAL SERVICES COMMITTEE

Chairman:	N. H. Dyer, M.D.	West Virginia
Vice Chairman:	Richard K. C. Lee, M.D.	Hawaii
Members:	Franklin M. Foote, M.D.	Connecticut
	Terrell O. Carver, M.D.	Idaho
	Dean H. Fisher, M.D.	Maine
	Edward W. Colby, M.D.	New Hampshire
	Melvin H. Evans, M.D.	Virgin Islands
	Albert E. Heustis, M.D.	Michigan
	Robert B. Aiken, M.D.	Vermont

Association actions:

1. Liaison Relationships with American Conference of Governmental Industrial Hygienists

That the Association of State and Territorial Health Officers establish liaison relationships with the American Conference of Governmental Industrial Hygienists comparable to those established with other non-official organizations.

2. Seminar on Administrative Practices in Occupational Health

That the executive committee of the Association of State and Territorial Health Officers refer the report on the seminar on administrative practices in occupational health developed by the various directors of State occupational health programs to the proper standing committee, and that this committee inform this Association and the Surgeon General of the Public Health Service of the significance of the issues and the action needed by State health departments and the Public Health Service.

3. Use of Occupational Illness and Accident Statistics

That the feasibility of a joint committee with the International Association of Governmental Labor Officials to develop better utilization of occupational illness and accident statistics, in order to strengthen preventive programs, be explored.

4. Accident Prevention Staff

That each State and Territorial health officer develop a method for coordinating accident prevention activities of the public health team.

5. Federal Training Grants

That the Association of State and Territorial Health Officers support or arrange for the initiation of legislation that will continue and expand the present program of Federal training grants.

6. Ambulance Services

That each State and Territorial health officer recognize a responsibility for, and assist the local communities in his State to develop, a program for the improvement of ambulance services.

SPECIAL COMMITTEE ON DISASTER MEDICAL SERVICES AND HEALTH MOBILIZATION

Chairman:	J. T. Herron, M.D.	Arkansas
Vice Chairman:	James R. Amos, M.D.	North Dakota
Members:	Russell E. Teague, M.D.	Kentucky
	Joseph E. Cannon, M.D.	Rhode Island
	Richard H. Wilcox, M.D.	Oregon
	Kirk T. Mosley, M.D.	Oklahoma
	G. D. Carlyle Thompson, M.D.	Utah

The State and Territorial health officers recommend:

1. Civilian Health Defense Mobilization Programs

   a. That by Presidential Executive Order the U. S. Department of Health, Education, and Welfare be designated and established as the national agency with complete and full responsibility for the civilian health and the civilian health defense mobilization program.

   b. That adequate funds be provided to proceed without delay for implementation of this program including staffing, research, training, stockpiling, program development, planning, and all other necessary activities.

   c. That funds be provided to States and Territories to implement State programs to assure an organized and coordinated national program.

   d. That the secretary be instructed to transmit this recommendation to the President of the United States, the Secretary of Defense, Members of Congress, to the Secretary of Health, Education, and Welfare, and the Surgeon General of the Public Health Service.

2. Funds for Disaster Medical Care

That at least $2 million of P.L. 85-606 funds be earmarked this fiscal year for the use of State health departments in developing the health capability of the populace for shelter occupancy and health protection through self-help, and that the secretary of the Association of State and Territorial Health Officers inform the Secretary of Health, Education, and Welfare and the Secretary of Defense of this recommendation.

Association actions:

3. Civil Defense Health Mobilization Grants

That the several State and Territorial health officers support or arrange for the initiation of legislation to provide necessary funds to accomplish civil defense health mobilization activities within and by State health departments in the same manner as the Public Health Service grant programs; and that the secretary of the Association inform the Congress of this recommendation.

4. Radiological Health Grants

That the several State and Territorial health officers, in view of the urgent need for increasing radiological health activities including surveillance and monitoring of air, milk, food, and water for radioactivity, reaffirm their support of Public Health Service financial grants to the States for these activities.

5. Self-Help Training Program

That the American Medical Association and the Public Health Service be commended for developing the medical self-help training program; that the American Academy of General Practice also be commended for its proffered assistance in carrying out the purposes of this program; and that each State and Territorial health department develop a cooperative program with the above organizations, and State components of the American Medical Association and the American Academy of General Practice, in order to bring the program to all those whom they serve.

SPECIAL COMMITTEE ON INDIAN AFFAIRS

Chairman:	R. N. Barr, M.D.	Minnesota
Vice Chairman:	Lloyd M. Farner, M.D.	Arizona
Members:	Stanley J. Leland, M.D.	New Mexico
	James W. Sampson, M.D.	Wyoming
	J. E. Peavy, M.D.	Texas
	R. H. Hutcheson, M.D.	Tennessee
	A. L. Gray, M.D.	Mississippi
	Edmund G. Zimmerer, M.D.	Iowa

The State and Territorial health officers recommend:

1. That the Indian health program be given a high priority, that this priority be continued, and that an annual increment of at least $5 million for the next several years be strongly considered by the Public Health Service.

SPECIAL COMMITTEE ON MIGRANT LABOR

Chairman:	R. L. Cleere, M.D.	Colorado
Vice Chairman:	Guillermo Arbona, M.D.	Puerto Rico
Members:	Floyd I. Hudson, M.D.	Delaware
	Robert H. Riedel, M.D.	Kansas
	Joseph Kovacs, M.D.	Guam
	Daniel J. Hurley, M.D.	Nevada
	William J. Rein, M.D.	Louisiana
	J. W. R. Norton, M.D.	North Carolina

The State and Territorial health officers recommend:

1. Summary Information on Migrant Health Projects

That the Public Health Service with the Children's Bureau cooperation provide State health officers with summary information on migrant health projects undertaken throughout the country.

2. Health Education Materials for Migrants

That the Public Health Service mobilize its resources to provide for State and local health agencies appropriate health education materials and assistance in methodology to be disseminated nationally, to make possible repeated exposure to basic health education concepts throughout the travels of migratory workers and families.

3. Seasonal Farm Workers Responsibilities for Health Betterment

That the Public Health Service strengthen and expand its cooperative exploration with States and local communities of methods of stimulating and assisting seasonal farm workers to assume more responsibility for their own health betterment.

4. Task Force for Health Record Evaluation

That a joint task force be set up by the Public Health Service including members from the Association of State and Territorial Health Officers, Public Health Service, Children's Bureau, and such other groups as may be appropriate to evaluate the effectiveness of the health record adopted by the Association of State and Territorial Health Officers in 1960 as a means of stimulating and facilitating the provision of health services to migrant workers and other family members with continuity of care as people move; and that this task force report to the Association on its findings at the 1962 annual conference.

Association actions:

5. Migrant Health Projects Information

That the several State and Territorial health officers provide current periodic reports to the Public Health Service so that information on migrant health projects can be disseminated throughout the United States.

6. Migrant Health Grants

That the Congress of the United States be petitioned to give favorable action during this year to the principles embodied by S.1130 as passed by the U. S. Senate authorizing grants for health services to domestic migratory labor; and that the secretary of the Association inform the Surgeon General, the Secretary of Health, Education, and Welfare, and the Congress of this recommendation; and that the several State and Territorial health officers contact their individual Governors and Congressmen in behalf of this bill.

7. Special Project Grant Criteria

That the Association approve:

a. The following criteria for establishing priority in special project grant assistance:

(1) The value of a project in developing techniques and demonstrating procedures.

(2) The extent of planned coordination within and between areas.

(3) The number of seasonal farm workers and families to be served.

(4) Awareness and consideration of cultural differences.

(5) The extent to which appropriate community groups are involved in project planning and development.

(6) The possibility of using the site as a training center.

(7) The likelihood that an area will assume more and more responsibility as time passes and will continue a project indefinitely as long as need continues.

(8) The availability of resources in the area.

(9) Progress toward more optimal family life for families of agricultural migrants.

b. The following areas of emphasis for migrant health program development:

(1) Expanded basic prevention, with particular emphasis on housing and field sanitation and on health education.

(2) Improvement of home-base conditions and services in order to help migrants overcome disabilities which handicap them in obtaining employment, and to reduce the incidence of health problems in work areas.

(3) Provision of continuity in health conditions and services through coordination of health planning and activity within and between States.

(4) Establishment of clinics to provide medical care at major points of labor concentration.

(5) Exploration of the feasibility of different methods of financing medical care.

(6) Development and demonstration of effective methods of extending services to migrants and improving their health conditions.

8. Coordination of Migrant Health Services

That members of the Association in States that are located along migratory streams plan and work together in the development of migratory labor health programs in order to achieve coordination of services and continuity of care.

9. Model Housing and Sanitation Code

That a model housing and sanitation code for migratory agricultural workers be developed and a program developed for effective implementation, and

That the Public Health Service provide staff assistance to a task force set up by the Association of State and Territorial Health Officers to develop and present recommendations to the Association and other appropriate agencies.

10. Health Supervision of Migrants' Children

That the State health authorities initiate development and maintenance of facilities for the health supervision of children of migrant farm workers and that legislation be promoted to make this effective; and that this legislation should make some provision for some of this responsibility to devolve on local health departments in areas where migrant labor is a factor.

RESOLUTIONS

PERTAINING TO PUBLIC HEALTH ACTIVITIES

ADOPTED BY THE

STATE AND TERRITORIAL HEALTH OFFICERS

Resolutions Committee

Chairman:	D. G. Gill, M.D.	Alabama
Vice Chairman:	Wilson T. Sowder, M.D.	Florida
	Charles L. Wilbar, Jr., M.D.	Pennsylvania

RESOLUTION NO. 1

Fifth International Conference on Health and Health Education

Whereas the International Union for Health Education is the only major international health organization representing both official and non-official health agencies, and

Whereas the Union is holding a Fifth International Conference on Health and Health Education in Philadelphia, Pennsylvania, during the first week of July, 1962, and

Whereas the American National Council for Health Education of the Public, with aid from the World Health Organization and the United States Public Health Service, has been actively planning, organizing, and supporting the conference, and

Whereas it is desirable, for the sake of improved public health practice throughout the world and for better international understanding among the peoples of the world, to have broad support for this important international conference from health departments throughout our Nation: Therefore, be it

RESOLVED, That the Association of State and Territorial Health Officers endorses the Fifth International Conference on Health and Health Education and urges member States to actively support the conference.

RESOLUTION NO. 2

Protection of the Public Health and Safety From the Dangers of Ionizing Radiation: Legislative and Regulatory Aspects

Whereas radiation may impair the health of the people if improperly utilized, and

Whereas State health agencies have traditionally been responsible for control of matters relating to public health, and

Whereas use of radioactive materials at any one installation generally results in hazards of limited geographical area, and

Whereas the Public Health Service has been cooperating with State health agencies for many years in the area of public health, and

Whereas there are major sources of radiation exposure to the general public, such as x-ray units and radium, which presently are under the sole jurisdiction of State health agencies: Now therefore, be it

RESOLVED, That at the Federal level, the primary responsibility for the protection of the public health and safety from the dangers of ionizing radiation should reside in the Public Health Service; and be it further

RESOLVED, That at the State level, the primary responsibility for the protection of public health safety in the State from the dangers of ionizing radiation should reside in the State agency which has primary responsibility for the protection of the public health; and be it further

RESOLVED, That there should be concurrent Federal and State jurisdiction in control of both construction and operation of facilities for the production or utilization of special nuclear material which presents hazards of accidental criticality, such as nuclear reactor plants; and be it further

RESOLVED, That efforts should be made to develop uniform radiation protection standards at all levels of government utilizing the body of information already available from Federal agencies; and be it further

RESOLVED, That each State should take necessary steps to develop a comprehensive program for control of sources of radiation.

RESOLUTION NO. 3

Five-year Census of the United States

Whereas the population of the United States is growing very rapidly and the rate of growth varies enormously between urban and rural areas, central cities and suburbs, metropolitan and non-metropolitan counties; and

Whereas these population changes have had and will continue to have major effects upon the needs for many public health facilities and services in most areas of the country; and

Whereas reasonably current population data for States, counties, and municipalities are essential to adequate knowledge of public health problems and to effective planning and administration of programs to deal with such problems; and

Whereas the population statistics provided by the 1960 census of population have been and are now most useful to State and local health agencies, but will become increasingly outdated as time passes; and

Whereas public health workers have twice in the past decade and most recently in 1958 expressed through formal resolutions of the American Public Health Association their need for more current population data for States and local areas: Now therefore, be it

RESOLVED, That a census of the population of the United States be taken at least every five years beginning with 1965 to provide, as a minimum, counts of the population by its basic characteristics for each county and municipality; and be it further

RESOLVED, That the Association of State and Territorial Health Officers authorizes and requests its president to arrange for appropriate presentation of the Association's views on this subject to the Congress and other appropriate agencies.

RESOLUTION NO. 4

Public Health Training

Whereas the newer public health responsibilities require well trained people; and

Whereas these responsibilities are being imposed by legislation and are expected by public opinion; and

Whereas the relationship between the educational and training needs in these newer responsibilities have not been recently evaluated in terms of resources available, and quality and quantity of teaching: Nov therefore, be it

RESOLVED, That the Surgeon General be requested to convene a conference of the representatives of the schools of public health, departments of preventive medicine of medical schools, schools preparing other technical health personnel, and representatives of State and local health departments to review the present educational program of preparing personnel for public health programs, the future needs and how these might best be met.

RESOLUTION NO. 5

Bureau of Environmental Health

Whereas the maintenance of a healthful environment for the people of the United States is becoming increasingly important and increasingly difficult to maintain with urbanization of the population and with the introduction of new and increased quantities of toxic materials into the surrounding milieu; and

Whereas it becomes increasingly evident that the handling of the many problems of environmental health by the Public Health Service calls for a major and cohesive organization, but one with considerable flexibility; and

Whereas the Final Report of the Study Group on Mission and Organization of the Public Health Service strongly recommended the creation of a Bureau of Environmental Health within the Public Health Service to include the various specialties within environmental health; and

Whereas it would seem that there is at present too great a restriction on the Surgeon General of the Public Health Service to allow him, within the overall scope of the Public Health Service as designated by Congress, to establish needed new units within the Service; and

Whereas creation of such a bureau requires Congressional action and such action has not yet been taken: Therefore, be it

RESOLVED, That a Bureau of Environmental Health be created in the Public Health Service in the near future as a separate major bureau of the Service; and be it further

RESOLVED, That the Surgeon General of the Public Health Service be given increased authority for establishing needed new units within the Public Health Service; and be it further

RESOLVED, That copies of this resolution be transmitted to the President of the United States, to the Congress, and to the Secretary of Health, Education, and Welfare.

RESOLUTION NO. 6

Legislation Concerning Fees for Home Nursing and Related Home Care Services

Whereas the increasing number of older people in our society has as its concomitant an increasing amount of chronic illness, and as a result the changing pattern of health needs of older or chronically ill individuals requires a careful appraisal of existing health services and the development of new ones; and

Whereas State and local official and voluntary agencies must develop more adequate services, and new organizational patterns for the care of patients out of the hospital, particularly for the chronically ill and aged; and

Whereas the current national trend is toward the development of insurance and other prepaid plans which will include home care, it is important that local health agencies offering home care services be in a position to make contracts and accept fees from such sources as individuals and families, Blue Cross, etc.; and

Whereas voluntary public health nursing agencies have had a long, satisfactory history of contracts and collection of fees for home nursing care services; and

Whereas public health nursing under voluntary auspices is available to only a portion of the population of the United States: Therefore, be it

RESOLVED, That this Association in order to facilitate the promotion of home care programs, including nursing services, encourage official health agencies to seek interpretation of existing legislation or encourage new legislation which could give them the authority to establish and accept fees for certain home care services provided to the ill and disabled.

RESOLUTION NO. 7

Project Grants of the Community Health Services and Facilities Act of 1961

Whereas the passage of the Community Health Services and Facilities Act of 1961 (P.L. 87-395) is a significant advance in the development of adequate health services for the chronically ill and aged; and

Whereas public health departments are in a position to exert leadership in the total planning, development, and operation of chronic disease public health programs, and provide consultation and guidance to public and voluntary health organizations in establishing services, studies, and demonstrations; and

Whereas the State health officers recognize the urgent time factor and need for rapid action in order to fulfill the intent of this Act; and

Whereas the State health officers express their willingness to work with the methods proposed on a trial basis; and

Whereas the Association of State and Territorial Health Officers has been assured by the Public Health Service staff that no projects will be approved until the comments of the State health officers have been received; and

Whereas this method is, per se, an instance of a modified administrative method which requires evaluation: Therefore, be it

RESOLVED, That the Surgeon General make such an appraisal with the full cooperation of the State health officers, and discuss the findings with the members of the Association, at or before the next annual meeting.

RESOLUTION NO. 8

Chronically Ill and the Aging

Whereas chronic disease and health problems of the aging are of major public health importance; and

Whereas a number of State health departments within the past several years have demonstrated recognition of the fact by increasing their emphasis in an attack upon chronic disease and health problems of the aging; and

Whereas recent Federal legislation expressed national concern for additional activity in this area and provided substantial support for such increased activity: Therefore, be it

RESOLVED, That the Association of State and Territorial Health Officers recognizes its responsibility to further stimulate the development of programs and services in chronic disease and health problems of the aging and recommends that State health officers who have not already done so, provide leadership and consultation to communities for increasing services to the chronically ill and the aged, by assigning full-time medical public health leadership to chronic disease programs in their respective State health departments.

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